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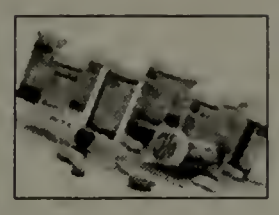

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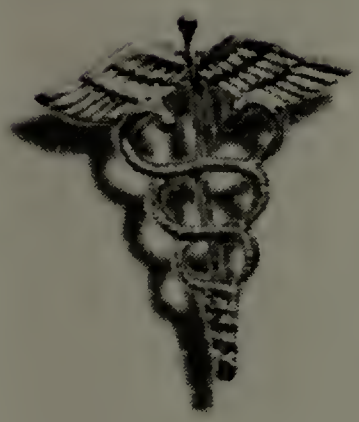

Massachusetts – A Caring Commonwealth

The Health Care Policy of Massachusetts

Senator Richard T. Moore
Senate Chairman, Joint Committee on Health Care

May 2003

Mission of Massachusetts Health Care Policy

In Massachusetts, we have a long tradition of caring for our own health, for the health of others, and for the well being of those who share our communities. Indeed, a "commonwealth," as defined in Webster's Encyclopedic Dictionary of the English Language is "a government for the common good." We, therefore, believe that a true commonwealth cares for "those who are at the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and the handicapped."

The Constitution of the Commonwealth of Massachusetts establishes a compact among the people and with their government to protect "...the power of enjoying in safety and tranquility their natural rights, and the blessings of life..." Health care, as a basic human need, is a fundamental, or core, responsibility of state government. Massachusetts state government has played a leading role in America's public health and mental health fields since the late 1860's.

The mission of the Health Care policy of the Commonwealth is to enhance the health and well being as demonstrated through improved health outcomes of all Massachusetts residents by promoting accountable, yet caring; cost-effective, yet high quality health care; using evidence-based, patient-centered methods of programming, treatment, and service delivery. Government health programs should be fully funded from broad-based tax revenues.

Vision for a Healthy Commonwealth

Healthy individuals, families and communities are the foundation of our Commonwealth. Massachusetts has a proud tradition of leadership in both public health and mental health. The first local Board of Health was established in Boston in 1790, chaired by Paul Revere, the world-renowned Massachusetts General Hospital was established in 1846, Worcester State Hospital, the first asylum for the insane was established in 1868, and the first Department of Public Health was established in 1867.

Massachusetts has made great strides in promoting patient safety, increasing access to health care, protection of patient rights, prevention of tobacco-related dependency and illness. Despite this record of progress, the public health system has insufficient resources, especially in this time of national economic instability, to address the needs of a doubling of the elder population, the challenge of teen pregnancy and low weight births. Too many Massachusetts residents, especially young people are obese. HIV-AIDS and Hepatitis C continue to infect a growing number of residents.

Our vision is for a Commonwealth that is a national, even world-class model of health care where all residents practice effective prevention, where health care providers are well-trained to offer effective, timely, compassionate, safe, affordable, high quality

care based on best evidence and proven outcomes and are accessible to every resident, where cultural competence is at high levels among all health professionals, where there is effective early intervention for all chronic disease processes, where patients are highly satisfied by every contact they have with the health care system at all levels across all delivery segments at each stage of their lives; where progress is regularly monitored, tracked and publicized with respect to our progress toward Health People 2010; and where health care providers are so highly satisfied with the health care environment that they deliver care in, and are committed to, remaining in the field. Specifically, we seek to foster the growth of a health care system in which:

- Doctors and staff take the time to know each patient and the patient's health care needs.
- Timely health care is delivered, without unnecessary waits or worries.
- Help is provided so that small health problems don't become big problems when early signs are missed.
- Providers make sure that patients get the right care at the right time.
- People and places are preventing dangerous errors in patient care.
- All stakeholders accept responsibility for use of finite financial resources.
- And that the system provides leadership in prevention of illness and accidents for all residents; and becomes especially skilled in caring for the young, the elderly, and the needy, the disabled, and the uninsured.

We recognize that these objectives can only be obtained by enhancing and expanding the exemplary efforts that have characterized the public-private partnership in health care in Massachusetts over the years, particularly through such efforts as the Coalition for the Prevention of Medical Errors and the Betsy Lehman Center for Patient Safety. Consequently, the focus of our health care policy, while prescriptive in some respects, must be built upon a foundation of collaboration including health professionals, purchasers, insurers, suppliers, government, and especially, consumers.

There are significant health disparities among populations in Massachusetts particularly for the poor in urban and rural settings, particularly among people of color. The vision shares the national objective for eliminating health disparities among all citizens, especially among people of color.

Our Massachusetts health care system must be guided by the standard John Winthrop set before his shipmates on the flagship Arbella at the birth of the Massachusetts commonwealth, as they faced the task of defining their community in a new and perilous frontier. "We must always consider," he said, "that we shall be as a city upon a hill – the eyes of all people are upon us."

STRATEGIC GOAL

The strategic goal of the health care system is to reduce the burden of physical and mental illness, injury, and disability, and to improve the overall health status and function of all Massachusetts residents including an emphasis on closing the gaps in health status by addressing the unique needs of vulnerable populations.

To that end the Commonwealth must develop with the health care system a strategic planning capacity that accurately identifies the long-term health care needs of the Commonwealth's citizens, that produces a long-term plan that is reviewed and updated on a bi-annual basis, including service capacity requirements, workforce development needs, preferred service delivery systems, clinical methodologies, patient volumes and budget projections.

Core Values of the Policy

- Personal responsibility of each individual for his or her own health is to be encouraged and community responsibility for the well being of all residents is at the foundation of the policy.

- Improved standards of care will be shared equitably with patients and help them to participate in their health care decisions.

- Accountability among all providers for successfully serving the health care needs of the people of the Commonwealth is measured by accurate, reliable, understandable, and timely financial and programmatic information to evaluate effectiveness and value to individuals, the community and the Commonwealth as a whole.

- The most current, evidence-based knowledge will be sought out and obtained when making decisions that affect the physical and mental health services of the Commonwealth.

- Health care professions are ready to utilize new technology that will support real time decision-making based on current evidence-based scientific information.

- Investing in technology, standardizing care when appropriate, and eliminating duplication of paperwork and administrative activity will help all stakeholders to work toward the important goal of streamlining a system that has not kept pace with the modern industrialized world.

- The significant role of health care in the economy of the Commonwealth as well as the quality of life and health is understood and valued.

- Government assumes the very difficult task of prioritizing health care needs.

- All people in Massachusetts live their last days in this life as comfortably as possible, in the setting of their choice, according to their wishes. Each terminally ill person, and their families, are supported by a caring Commonwealth.

Strategies Supporting Core Values

- To recognize the national leadership of the Commonwealth in providing access to health coverage for uninsured residents; adults, children, legal immigrants, and long-term unemployed, and to encourage the development of policies and programs which restore, maintain, and expand this leadership.

- To deliver results that are satisfactory and useful to the people and communities that are directly served by the Commonwealth's physical and mental health policies and programs, and to the taxpayers of the Commonwealth and Federal agencies who provide the resources to support those policies and programs.

- To maintain a work environment that encourages creativity, diversity, innovation, teamwork, accountability, continuous learning, a sense of urgency, enthusiasm, celebration of achievement and the highest ethical and professional standards.

- Recognizing the complexities of sustaining funding for the type of health care system that supports this policy, all stakeholders, including the Commonwealth, must be unified in the effort. It is critical that all stakeholders support the leadership in the public sector in its efforts to reconstruct a system of care that will ensure quality access to care for patients as well as address the rising cost of health care.

- To focus consistently on the prevention of mental illness, disease, and societal problems that may hinder the progress of the Commonwealth's diverse population toward the goals, and to build healthy communities that enhance the health of our residents.

- To encourage collaboration of public and private sectors in achieving the goals and to ensure that all providers understand and accept responsibility for implementing the health care policy of the Commonwealth and receive support to achieve success in their roles.

- To maintain a work environment that encourages creativity, diversity, innovation, teamwork, accountability, continuous learning, a sense of urgency, enthusiasm, celebration of achievement and the highest ethical and professional standards.

- To promote standards and benchmarks that measure health progress and reporting systems that avoid duplication and do not add unnecessarily to the administrative burden of any aspect of the health care system.

- To encourage the development of policies which maintain and expand the economic leadership of health care especially in the areas of biomedical and pharmaceutical research, development and processing.

- To engage all key stakeholders in health care to redesign a system that is safer, easier to access, higher quality and more cost-effective.

- To provide an effective base level of health care, restore programs in prevention that were cut during the 2001-2003 economic slump, through increased revenue, additional federal assistance, or reprogramming of existing revenue. (For list see Appendix C – pp. 33-40).

Health Care Goals

(Note: Numbers assigned to goals and order of listing objectives, do not necessarily reflect a priority ranking at this time.)

GOAL 1. FOCUS ON PATIENT-CENTERED CARE.

To Improve the Patient Experience with Health Care by encouraging physicians and all health care professional to incorporate the six values of patient care in their practices, and recognize the importance of physicians, dentists, and health care organization leaders in supporting and implementing goals that value the needs, concerns, and respect of patients.

There are six aims for improving the patient experience:

- **Safety** – striving to make patients and all health professionals safe from harm resulting from medical error.

- **Effectiveness** – matching care to science; eliminating overuse, underuse, and misuse in the delivery of health care.

- **Patient-centeredness** – honoring the individual and respecting choice.

- **Timeliness** – reducing unnecessary delays in the delivery of care.

- **Efficiency** – reducing waste and promoting the best quality care at a reasonable cost.

- **Equity** – closing racial, ethnic, regional and economic gaps in quality and accessibility of health care.

While quality is an important part of protecting the patient experience, excessive testing of patients needs to be reviewed. An April 2002 report by Common Good of 300 doctors found that 79% order more tests than they would based on their professional judgment and 74% said they refer patients to specialists more often because of fear of lawsuits. Unnecessary tests do little to improve the quality of care. The fact that four out of five doctors feel compelled to practice defensive medicine raises issues about the impact of the tort system on the quality of care.

Immediate Objectives (2003-2004)

- Strengthen the Board of Registration in Medicine's Patient Care Assessment Program to provide leadership in developing innovative quality improvement efforts that focus on patient-centered non-punitive methods.

- Initiate efforts to recruit nurses from ethnically disadvantaged populations. Having professionals with first-hand knowledge of the challenges that are faced in ethnically diverse communities will provide excellent advocates for equitable access to care.

- Develop, implement, and enforce strict ethical guidelines consistent with nationally recognized ethical norms governing the relationship between pharmaceutical manufacturers and pharmacy benefit managers and those licensed to prescribe medication.

- Prohibit the use of free samples of medication provided by pharmaceutical manufacturers or others and require a coupon system on which the prescribing agent authorizes a prescription for free or discounted samples redeemed at the patient's pharmacy.

- Fund and Implement the Betsy Lehman Center for Patient Safety and Medical Error Reduction established pursuant to Chapter 177, Section 7 of the Acts of 2001.

- Review the impact of current medical malpractice law and procedures to determine if the system adequately addresses the needs of injured parties and promotes improvements in the safety and quality of care to reduce the chances of future mistakes.

- Explore and implement a single center in the state for all billing and insurance paperwork systems, public and private.

- Incorporate cultural competency with diverse populations into medical and allied health school curricula.

Short Term Objectives (2005-2010):

- Based on an analysis of national quality reports or measures employed to assess quality elsewhere, consider the development of a Massachusetts Quality Report on Health Care Delivery to provide a barometer for the people of the Commonwealth, health care professionals, and policy makers by which they can measure and compare quality of care as well as identify under-performing providers and weak areas of the system as a whole. The Quality Report would assess progress in the Commonwealth toward each of the aims for improving the patient experience based, in so far as possible, on standards developed by national organizations, and by the specialty and subspecialty organizations best suited to their articulation. In determining the efficacy of a state-based quality report, policymakers should consider the method used in producing national reports, the utility of such reports in promoting quality, and the cost-effectiveness of such an effort.

- Develop Performance Standards for Physicians and means of assessment to evaluate their clinical proficiency, their professional behavior, their personal responsibility, and their cultural competence to serve diverse populations; and implement a pilot program to validate and refine the standards once agreed upon by physicians, policy makers and other stakeholders, then implement the Performance Standards for Physicians in all acute care hospitals and develop standards for all other physicians not credentialed in an acute care hospital and for nurses, pharmacists, dentists and allied health professions.

- Develop performance standards for institutions that include the documentation of patient outcomes by race, ethnicity, and other criteria, and the development and implementation of remediation plans where inequities are found.

- Develop guidelines for a system of computerized prescription order entry, drug distribution, and administration systems for every licensed health care facility in the Commonwealth and begin implementation with targeted financial implementation and support including revising DPH regulations that prohibit transmitting prescriptions over the internet if security can be assured.

- Develop a standardized universal computerized medical record that enables seamless transfer of patient information between all providers and the patient.

- Manage the increase in health insurance premiums and medical malpractice premiums by improving quality and safety providing lower premiums to those who follow best practice evidence-based medicine that produce favorable patient outcomes rather than simply limiting judgments and settlements for victims of poor quality care.

- Pilot a system of candor and honesty in hospitals and skilled nursing facilities when mistakes in care occur that stresses appropriate compensation for injured parties, the limits, if any, of enterprise liability, and assurance that steps will be taken to minimize a recurrence of the adverse event. In addition, when close calls occur that could have resulted in injury but did not, there must be a no-fault system that allows this information to be used for education and system re-design rather than as evidence of malpractice. As preconditions for the "framework of candor and honesty" that must be developed, law must protect confidentiality of information used to develop internal quality responses as well as external communications, and the medical malpractice system must be reformed along the lines of a no-fault system similar to the workers compensation system. The framework should measure the value and effectiveness to patient care of the statutory cap on hospital liability and the potential for developing a system requiring compensation of all injured parties.

- Initiate a program to reduce waiting times in hospitals and doctors' offices between the time a patient checks in and when they receive medical attention.

- Implement computerized prescription order entry and distribution systems in every licensed health care facility.

- Achieve compliance with nationally recognized safety and quality standards for protecting adult patients – such as the "Leap Frog" principles, in every acute care hospital in Massachusetts. Support the development of a comparable system of safety measures – a set of pediatrics-applicable standards consistent with the "Leap Frog" principles that would apply to hospitals serving children.

- Require purpose use and/or therapeutic objective on all prescription orders.

- Educate the public to the reality that health care is as much an art as a science and that there may be the potential for bad patient outcomes even when everything is done correctly

- Regulate Internet pharmacies to ensure their compliance with state pharmacy practice laws and regulations.

Long Term Objectives (2011-2015):

- With leadership from the Betsy Lehman Center for Patient Safety, implement a culture of safety among all health care providers.

- Develop evidence based safety standards for office practices and implement a system of inspection and licensure to ensure patient safety in physician office practices.

- Establish a statewide system for all health care providers based on candor and honesty when mistakes in care occur that stresses appropriate compensation for injured parties and assurance that steps will be taken to minimize a recurrence of the adverse event.

- Encourage the establishment of secure physician-patient e-mail as a means to foster patient-centered care.

- Explore and implement a single center in the state for all billing and insurance paperwork systems, public and private.

- Incorporate cultural competency with diverse populations into medical and allied health school curricula.

- Lead efforts nationally to limit or counter direct to consumer advertising of pharmaceuticals through improved patient education.

GOAL 2: FOCUS ON PREVENTION AND CARE MANAGEMENT.

To strengthen prevention and care management with a focus on altering our citizens' health diminishing behaviors as the primary objectives of all aspects of health care in the Commonwealth.

We know that behavior accounts for 80% of the health problems, yet receives less than 20% of the dollars spent in health care. Access appears to inappropriately receive 80% of the dollars spent in health care, yet will only impact 20% of the health problems. Behavior changes among our citizens aimed at tobacco cessation, obesity intervention, work and sports safety, and appropriate use of alcohol must be our primary focus.

Care management programs for individuals suffering from asthma, congestive heart failure, and diabetes, developed by health plans have become national models for helping individuals manage their care and improve their over-all well-being. As more states turn to these programs to lower their health care costs and provide more appropriate care to Medicaid beneficiaries, Massachusetts should implement similar programs for high risk patients suffering from chronic disease.

As former Dr. C. Everett Koop, former U.S. Surgeon General, stated recently, "We are at the dawn of a new age in the relationship among volition, morbidity, and mortality. Most people's volition is not to get sick or not to die. In earlier generations, people got sick and died from things they didn't want or like such as famine, plague, or war. In the

last two generations, most people have gotten sick and died from things the want to do and like such as eating and relaxing (not controlling diet and exercising), smoking, drinking to excess, practicing unprotected sex, using drugs, driving irresponsibly – lifestyle choices. People need to DO those things that promote good health and DON'T do those things that are harmful. We all have to learn to say" NO" to lifestyle choices that are harmful."

Immediate Objectives (2003-2004):

- Develop a program that permits instantaneous contact between the Department of Public Health and the respective municipal departments and boards of health relative to prevention or containment of epidemics or for other appropriate public health needs.

- Complete the Statewide Prevalence Study of Autism and implement recommendations based on the study and support the DOE/DMR "Initiative to Keep Children at Home." Develop a plan on how best to serve children and adults with autism spectrum disorders, including those who are not mentally retarded.

- Encourage all health plans, insurers, and other who fund health care services to fund testing and treatment for CRP (c-reactive protein) where deemed appropriate by physicians; and encourage all providers to promote testing of all deemed at risk and, where needed, treatment including appropriate mediation, recommend diet and exercise or both to reduce incidence of heart attack, stroke, Type 2 Diabetes, Incident Hypertension, and venous thrombosis.

- Develop a program focused on the school setting to combat the epidemic of obesity among the youth of the Commonwealth.

- Support passage of federal legislation known as the "Physical Education for Progress – P.E.P. Act - Senate Bill 1159. (Note: Only one state, Illinois, currently requires daily physical education for grades K-12. Almost half of young people aged 12 - 21, and more than a third of high school students, do not participate in vigorous physical activity on a regular basis. Fewer than one in four children get 20 minutes of vigorous physical activity every day ... The impact of our poor health habits is staggering obesity-related diseases cost the nation more than $100 million dollars a year.)

Short Term Objectives (2005-2010):

- Encourage primary care doctors to include simple tests to detect hearing loss that affects up to 40% of patients 65 and older. Research suggests that both older patients and primary care doctors are ill informed about hearing loss that

is easily treated for many and often under-diagnosed. It is a major cause of depression and decreased quality of life among senior citizens.

- Develop incentives for people to seek treatment at community hospitals and neighborhood health centers to reduce the percentage of patients (currently estimated to be 44% in Massachusetts compared to 12% nationally) who believe that only teaching hospitals provide the most effective health care.

- Honor the voters' intention from the 1992 initiative, and the Attorney General's efforts in the 1998 Master Tobacco Settlement by restoring the Massachusetts Tobacco Control Program to a position of national leadership in reducing tobacco use among the youth of the Commonwealth.

- Implement a diabetes education and screening program that targets high-risk populations such as Spanish, Portuguese, and American Indian.

- Develop a statewide network of healthy community efforts that work towards enhancing the health of communities, building on the World Health Organization's healthy communities model and the work already done in Massachusetts by many communities.

- Improve information, outreach and training about Asperger's Syndrome to community organizations, schools, clinics, service providers and other health professionals and develop appropriate services and resources to benefit those with Asperger's and their families.

- Develop a Partnership Approach to Care Management, similar to the Pittsburgh Regional Healthcare Initiative, by working cooperatively with health care policy makers, providers, payers, and consumers to provide information to consumers in a culturally competent manner to help consumers gain the knowledge and accept the responsibility to prevent or manage chronic diseases, and to begin pilot programs in asthma, diabetes, depression and congestive heart failure. (See Appendix B, pp 30-32)

- Develop a Medicaid system of Pay for Performance to provide financial incentives for improved patient outcomes through disease management through negotiated targets of performance that are fair and risk-adjusted with providers with such diseases as asthma, depression, diabetes, heart failure, Alzheimer's, arthritis, coronary artery disease, HIV/AIDS, hyperlipidemia, schizophrenia, otitis media, and seek ways to make medication to manage these diseases more affordable.

- Promote a statewide initiative in injury prevention with both a child-oriented emphasis and senior citizen emphasis through emergency department surveillance and public education initiatives, as well as specific legislation like improved seat belt and booster seat laws.

- Develop a program to prevent environmental illnesses through "healthy homes" approaches including the installation in housing of carbon monoxide monitors.

- Restore Universal child and adult immunization programs.

- Restore Youth Wellness Prevention Programs.

- Ensure that all residents have access to screening for hypertension, diabetes, high cholesterol, obesity, and cancer.

- Prohibit smoking in every public facility and workplace in the Commonwealth

Long Term Objectives (2011-2015):

- Provide adequate financial support to sustain existing school health facilities and enhanced school health programs for every student in the commonwealth expanded to achieve a ratio of one nurse for every five hundred students to decrease absenteeism, increase primary care, and decrease emergency department utilization. School health should be supported, in large measure by reimbursements from Medicaid, private health plans, the Uncompensated Care Pool and grants from foundations and the federal government.

- Expand the Massachusetts Partnership for Care Management by working cooperatively with health care policy makers, providers, payers, and consumers to provide information to consumers to help consumers gain the knowledge and accept the responsibility to prevent or manage chronic diseases, to implement statewide programs in asthma, diabetes, depression and congestive heart failure and launch pilot programs for pulmonary disease, gastro-esophageal reflux disease, hypertension, and combinations of two or more diseases.

- Develop Commonwealth Centers of Excellence in Chronic Disease Care Management by targeting public and private resources to support centers that involve academic medical centers, affiliated community hospitals and neighborhood health centers to focus on targeted disease management for such illnesses as cystic fibrosis, epilepsy, hemophelia, HIV/AIDS, multiple sclerosis, sickle cell anemia, schizophrenia, and urinary tract infection.

- Develop a "single point of entry" or coordinating agency to assist consumers with accessing vital information and care necessary to effectively manage chronic illness, building upon the success of the MS PASS program administered by the Office of Health and Disability within the Department of Public Health. The focus of such an effort should be to establish a specific

agency or inter-agency coordination to address the complex needs of adults living with chronic illness.

- Prohibit smoking in every public facility and every workplace in the Commonwealth.

- Encourage all employers that provide health insurance for employees and families and all who provide health insurance or health plans to implement prevention programs, including nutrition, exercise, smoking cessation, and other proven efforts to reduce the human and economic costs of illness.

GOAL 3: FOCUS ON HEALTH CARE FOR ALL.

To develop universal access to care for every resident of the Commonwealth for both physical and mental health needs and that a financing mechanism exists which is fair, and equitable to all stakeholders, so that optimum health is achieved for all citizens that is affordable and in a manner which is fiscally responsible.

Of course, we must all share in paying for all of the care that is needed. In order for universal access to be achieved, a financing mechanism that is sustainable must be put in place. It cannot rely on the outworn practice of cost shifting, but on making up front decisions about where to spend a finite pool of money on an annual basis. We understand that that there is not enough money to meet all of the health needs of all of our citizens at the same time. Therefore, decisions must be made about where best to spend resources, based on measured health outcomes of the population and where remaining problems lay. Health insurance mandates and government oversight need to be evaluated on cost-effectiveness, along with other factors affecting premiums, in light of a recent Price Waters Coopers study suggesting that nearly 15% of the increases in health care premiums in 2001-2002 was directly attributable to government mandates and regulation.

Studies suggest that 1% of the populations spends 25% of health care dollars, 4% spend another 30%, 44% spend 40%, and 50% spend 5%. We need to concentrate on managing the care of the 5% who collectively spend 55% of available health care dollars. Attention needs to be directed toward helping people to better manage their chronic conditions to avoid more serious health emergencies. Our focus as a Commonwealth should be to expand insurance coverage, and even in difficult economic times we might be forced to limit benefits, but completely cutting people off from health coverage is unconscionable in a Commonwealth of Caring.

Immediate Objectives (2003-2004):

- Review current legally mandated benefits that affect the premium costs of private sector health plans to ensure that they are cost effective and add legitimate value to the product.

- Restructure the Uncompensated Care Pool to equitably redistribute the cost, to improve accountability, to standardize benefits, and to prevent abuse, reward hospitals when efficiencies and incentives to ensure that care is provided in the most appropriate settings such as preventive efforts that reduce emergency department reliance through programs such as school-based and community-based health centers.

- Develop common agreement on the menu of services that will be paid through the Uncompensated Care Pool and Medicaid.

- Reinvigorate the Insurance Partnership, supported by the Uncompensated Care Pool, to make it more attractive to employers and employees and to encourage organizational memberships of small business associations such as chambers of commerce and the farm bureau federation with an effort to share the costs more equitably among all employers including those that do not currently provide health insurance.

- Review administrative requirements on health plans and insurers that add little or no value to the members or those insured and that require burdensome disclosure of material that members or those insured may only need periodically analyzing their impact on premium charges that, as they increase, may affect affordability and impact opportunities for access to care.

- Impose a moratorium on any new mandates for health coverage so that employers maintain the necessary flexibility to manage rising medical costs and the sunset provision on the mandate review process needs to be eliminated.

- Encourage and assist the University of Massachusetts Medical School to become a Not for Profit Pharmacy Benefit Manager to serve Massachusetts and, if there is interest, other states in the Northeast.

Short Term Objectives (2005-2010):

- Develop Medicaid budget strategies that help to manage the system to ensure health care for those in need within reasonable costs through 1. Quality Assurance Initiatives - care management, centers of excellence, enhanced Medicaid/drug review management, practice pattern analysis, and enhanced primary care case management; 2. Utilization Management Initiatives – patient lock-in program, fraud/abuse detection system/audit program, clinical criteria application, third party liability edits, drug therapy parameters; 3. Operational Systems Initiatives – decision support systems, reimbursement policies, and preferred drug lists, and 4. Access Initiatives – which maintain and expand efforts to enroll all eligible residents in Mass Health programs, and that encourage the responsible use of Mass Health services by newly enrolled residents.

- Strengthen school and community-based health centers and expand the number of centers to reach all underserved populations.

- Require all employers to provide health insurance or contribute to a fund that allows access through Medicaid or the Uncompensated Care Pool.

- Restore the Massachusetts Promise to offer health insurance coverage to all children.

- Fully fund the Medicaid system to insure that providers are paid rates that cover the actual cost of the services inclusive of the health care systems' requirements for capital to expand and renovate facilities and to acquire capital equipment.

- Government must not be allowed to shift obligations onto private payers or providers that place additional strains on private payers.

- Increase the sales tax by one cent and dedicate the revenue to a health care policy implementation fund to assist in supporting the goals and objectives of the comprehensive health policy.

Long Term Objectives (2011-2015):

- Require every resident of the Commonwealth to be covered by Health Insurance that meets the coverage offered through Medicaid following an educational campaign to increase public support for the concept.

- Establish school-based health centers in every regional school district and urban district in the Commonwealth.

- Encourage the development of better community-based urgent care programs and facilities available during evening and weekend hours.

GOAL 4: FOCUS ON STRENGTHENING THE PUBLIC HEALTH SYSTEM.

To strengthen the public health system in the Commonwealth and its communities to implement the objectives of Healthy Communities 2010 and to effectively respond to the threat of bio-terrorism or natural disasters through an "all hazards approach."

Community health centers and school based health centers are proving to be a most effective delivery system. All health care is local. The focus for the public health system should be to leverage local strengths where they exist, and to shore up local efforts where there are weaknesses. Consideration needs to be given to reorganization of the

Commonwealth's public health system and holding regions accountable for statewide performance measures that the Commonwealth must commit to monitor and report back to the local community. Each community must be empowered to identify its own public health issues and create solutions.

Immediate Objectives (2003-2004):

- Develop a Health Alert Network to link the state Department of Public Health with local health departments and boards of health by Internet and/or instant messaging so that state or CDC health alerts and other critical public health information can be transmitted instantaneously.

- Develop financial and legal support systems to facilitate vaccination of an adequate number of health care workers for small pox once the safety of the vaccine is assured.

- Establish a meningitis vaccination program for all "college-bound" high school seniors.

Short Term Objectives (2005-2010):

- Promote training and core support for healthy community initiatives in every community of the Commonwealth.

- Enhance the role of local public health departments to work with local officials, providers, and citizens on issues important to the community such as substance abuse, nutrition, sanitation, domestic abuse, environmental health and pollution, smoking, teen pregnancy, and reproductive diseases.

- Develop a concerted effort to combat substance abuse as a major health initiative that affects all aspects of society – joblessness, homelessness, truancy, violence, motor vehicle accidents, homicide, etc.

- Increase the collective ability of the public health system and health care providers to track and respond to epidemics and infections through means such as using technology to monitor activities such as hospital admissions, doctors' office visits, pharmacy sales, and other means to identify unusual patterns in the community that may signal an epidemic or terrorist event.

- Equip public facilities of sufficient size throughout the Commonwealth with automatic portable defibrillators to reduce serious injury and death from heart attacks by fifty percent in five years.

- Equip public facilities with epi-pens and ensure that sufficient trained personnel are available to reduce by fifty percent deaths and serious injury from allergic reactions.

- Promote enhanced school health programs to provide school nurses in every school building in Massachusetts.

- Establish a statewide program to reduce tooth decay and gum disease in Massachusetts by fifty percent.

- Improve the health programs for the state's correctional facilities and for re-integration of ex-offenders in their communities.

- Promote a campaign to educate young people not to engage in "binge-drinking."

- Collect data regarding the health status and develop programs to improve the health of Lesbian, Gay, Bisexual, and Transgender residents, noted in Healthy People 2010 as populations experiencing health disparities.

Long Term Objectives (2011-2015):

- Public facilities are equipped with automatic portable defibrillators and epi-pens sufficient trained personnel are available to reduce by seventy-five percent deaths and serious injury from heart attacks and arrest and allergic reactions respectively.

- Massachusetts is first among all states in meeting the goals of Healthy Communities 2010.

- Implement a system throughout the Commonwealth where abuse of any kind – spousal, child, sexual, elder, etc. – is recognized, terminated, and treated professionally.

- Implement a system in Massachusetts to help senior citizens extend the period of higher mental and physical functioning to remain independent as long as possible.

- Establish a statewide program to reduce tooth decay and gum disease in Massachusetts by an additional fifty percent (or seventy-five percent over the ten year period).

- Develop a system of universal health care (though not, necessarily, a single-payer model) so that every resident of the Commonwealth has access to health care

GOAL 5: FOCUS ON PREPAREDNESS FOR HEALTH EMERGENCIES.

To strengthen the emergency medical system in the Commonwealth, and increase the ability of individuals and communities to respond to medical emergencies and mental health episodes.

For some health emergencies, there are only minutes between the onset of a crisis event and the need for treatment, for others it can be measured in hours or days. First responders, emergency medical services and hospital emergency departments are critical to providing this treatment. However, more citizens trained in first aid, CPR, and other life-saving techniques could supplement the emergency medical system and reduce death and serious injury among our citizens.

Immediate Objectives (2003-2004):

- Develop and exercise emergency response plans for each region involving evacuation planning, community shelter, use of schools, hospitals and other public facilities.

- Develop comprehensive training programs focused on biological, chemical, and radiological terrorism including decontamination procedures, testing, and treatment.

- Equip emergency responders with appropriate personal protective equipment related to weapons of mass destruction and train for emergency preparedness.

- Health care providers, first responders and others must be trained, equipped and staffed to meet the threat of biological, chemical or nuclear terrorism.

- Ensure that all emergency response personnel adhere to standards aimed at understanding specific child-oriented principles and practices and that they are trained and equipped to care for and transport children.

Short Term Objectives (2005-2010):

- Develop a communications system that allows all (federal, state, local, private) emergency responders to communicate with each other on secure frequencies and to train and equip responders in all of the Commonwealth's EMS regions.

- Health care facilities, as first responders in time of disaster, must be designed or retrofitted, and equipped for decontamination and for accommodating large numbers of special populations such as children in response to terrorism or other tragedies.

- Encourage all restaurants, schools and other public facilities to maintain epi-pens to minimize death and severe disability from allergic reactions to food, insect bites, etc.

Long Term Objectives (2011-2015):

- Require all public facilities to have available automatic defibrillators and trained personnel available to minimize death and severe disability for heart seizure and heart attack.

- Develop a safe, clinician-based Epi-pen program for restaurants, schools and other public facilities to maintain epi-pens to minimize death and severe disability from allergic reactions to food, insect bites, etc. provided that a system of training, protocol, recertification, and strong medical oversight can be provided.

GOAL 6: FOCUS ON RESOURCE STABILITY.

To establish a funding mechanism to support the physical and mental health needs of the Commonwealth during cyclical economic downturns.

We have learned the painful reality that programs aimed at improving health outcomes, as vital as they may be, are often sacrificed in short-term economic downturns. This sets back efforts to prevent more serious and expensive efforts. Recent policy decisions to cut dental benefits for 550,000 adults in Massachusetts seems shortsighted given the percentage of health care dollars consumed by dental health. In addition, the termination of nearly 50,000 Mass Health Basic Members – many with mental illness or substance abuse issues or the capping and possible elimination of Prescription Advantage reduces access to care and produces unacceptable health outcomes. A health care "rainy day" fund or other mechanism to avoid cuts in core state health services appears to be needed to maintain progress toward state health policy goals which become even more critical in a weakened state or national economy.

Immediate Objectives (2003-2004):

- Initiate research into financial mechanisms to protect health care quality and outcomes during difficult economic periods.

- Provide for the development of five year financial plan accounting for expenditures and revenues relating to Medicaid and any other health assistance programs administered by state agencies in order to promote better planning for public funding of health care for those served by Medicaid and other health assistance programs.

Short Term Objectives (2005-2010):

- Direct all funds from the tobacco settlement to a Health Care Security Trust that will be available to off-set deficiencies in health care funding as the health care needs and usage increase or as revenues prove inadequate to meet current needs.

- Ensure that all revenue received for health purposes is applied to health program expenditures rather than for non-health general fund purposes.

Long Term Objectives (2011-2015):

- Expand the Health Care Security Trust Fund by dedicating a portion of net revenues to the fund so that surplus revenues from years of prosperity can be set aside and available for the cyclical downturns in the economy.

GOAL 7: FOCUS ON SUPPORTING CAREGIVERS.

To develop a system to ensure an adequate supply of highly competent, empathic and diverse health care professionals to meet the workforce needs of the Commonwealth supported by the latest, most effective medical technology and health management and information systems.

There is already an acknowledged shortage of nurses and certain specialties such as radiology and pharmacy. Some doctors, who receive their education and training in Massachusetts are also choosing to practice elsewhere. The population of the Commonwealth is also changing. The percentage of older citizens will double over the next fifteen years requiring more health care and the diversity of residents of color and of many ethnic and national groups dictates the need for the health care system to respond to these changing needs. Not enough young people are entering the health professions, there are insufficient incentives for others to remain in direct care, and there are limited efforts to attract minorities into health care positions. A comprehensive effort is needed to make health care an attractive field once again, and to retain those already serving.

Immediate Objectives (2003-2004):

- Develop a workforce plan that assesses the current status of the Commonwealth's health care workforce, including the current practice environment and its affect on shortages in physician specialties, and lays out a plan to immediately expand the capacity of existing nursing and allied health care higher education programs to address the high vacancy rate that exists throughout the system.

- Require Regional Employment Boards, Workforce Training programs, and welfare to work programs to focus retraining efforts on the needs of the health care system.

- Encourage the University of Massachusetts Medical School to become a testing center for the new clinical skills exam administered by the United States Medical Licensing Examination Board.

- Enact state pharmacy practice provisions authorizing pharmacists to adjust patients' therapeutic regimens in collaboration with prescribers.

Short Term Objectives (2005-2010):

- Develop comprehensive training programs that focus on biological, chemical, and radiological terrorism including decontamination procedures, testing, and currently available treatment.

- Address the increasingly non-competitive physician practice environment that exists in the Commonwealth.

- Establish a pilot program to support the education of nurses at all levels from nurse assistants to nursing faculty through scholarships, childcare and housing grants, mentorships and other incentives including the creation of career ladders and assist recent immigrants to take advantage of such programs.

- Work with health care institutions, educational institutions and community based organizations to identify critical skills shortage areas and assist incumbent workers and others to acquire the education and training necessary to fill these critical health care positions, by providing career ladders, low/no cost educational and training opportunities, collaboration with employers for job placements, etc.

- Conduct organizational/institutional assessments of cultural competency and expand initiatives to address health care labor shortage of people of color such as: youth to health career programs, diversifying the population of medical and allied health schools and integrating cultural competency course work in the health care professions curriculum, and strengthen linkages between higher education and career ladder programs.

- Recognize the Certified Geriatric Pharmacist credential as meeting the requirements for advanced practice initiatives and continuing education.

- Fund programs to create pathways from high school into health professions: programs, scholarships, etc.

- Increase enrollment capacity of existing nursing and allied health educational programs.

Long Term Objectives (2011-2015):

- Establish mentoring programs with high school and elementary school students for health professionals to encourage students to consider careers in health care.

- Support the separation of Medicare funding from graduate medical education in the federal budget.

- Support high quality mathematics and science programs in the schools of the Commonwealth.

- Conduct organizational assessments of hospitals and community health centers regarding workforce gaps. Develop and implement plans to address gaps.

- Develop programs to retain current nurses.

- Establish a Commonwealth-wide initiative to educate junior high and high school students about careers in health care and research, to promote a broader interest in these fields among a larger number of local area students.

- Provide incentives to Massachusetts educational institutions to offer a wide variety of programs in health care fields and encourage student participating by providing special financial incentives for those who choose and successfully achieve a health care careers.

- Work with Massachusetts educational institutions to offer certificates and degrees in health care to working adults interested in advancing or moving into health care careers, in formats (especially for clinics) that accommodate the needs of the full-time worker.

GOAL 8: FOCUS ON THE VITAL ROLE OF HEALTH CARE IN THE MASSACHUSETTS ECONOMY

To encourage the economic success of the health care system in its role as a major component of the Commonwealth's economic prosperity so that Massachusetts is a national leader in medical and bio-medical technology.

Massachusetts must nurture its world-class health care economy that is too often taken for granted. The legislative and regulatory environment should focus on fostering the sector's growth and achievement rather than providing more cost elevating mandates that add little value or improve health outcomes. Health care employs a large number of the Commonwealth's residents either directly or indirectly, and needs to be encouraged to grow and prosper.

Immediate Objectives (2003-2004):

- Building upon the "We Care" and "Why Care?" initiatives of the health care network, promote greater public understanding of the critical economic development role of health care at all levels.

- Promote policies that support affordable housing and childcare services for the health care workforce and those engaged in biomedical research and medical technology development.

Short Term Objectives (2005-2010):

- Reduce legal and administrative burdens and increase incentives for biotechnology initiatives to encourage such business that research and develop their products in Massachusetts to also locate and expand production facilities in the Commonwealth balanced with a concern for public health issues in biotechnology and fair revenue policy.

- Encourage the development of partnerships between private industry and academic research institutions through a tax incentive to encourage industry to partner with academia so that industry more coherently supports longer-term research initiatives.

- Develop financial assistance programs through mechanisms such as the Health and Educational Facilities Authority and a Health Care Technology Bond to assist providers with development of electronic patient records, computerized prescription order entry and distribution systems, to ensure state of the art technology in health care.

Long Term Objectives (2011-2015):

- Ensure adequate reimbursement rates for health care providers through Medicaid, Uncompensated Care Pool, Group Insurance Commission and other public purchasers based on improved health outcomes.

- Encourage the development of assistance or incentives to promote pharmaceutical and biomedical development and processing/distribution facilities.

GOAL 9: FOCUS ON AGING WITH DIGNITY.

To develop a system to provide care with dignity in the least restrictive environment appropriate to the needs of each individual and their family so that every resident of the Commonwealth shall receive end of life care when needed.

Few, if any, seniors want to be institutionalized for their health needs. The Supreme Court's Olmstead decision calls upon government to lead efforts to help elders and those

with handicaps to live in their homes or, at least, in their communities. With the number of seniors expected to double in the next fifteen years and with many experiencing health conditions that come with longevity, a new vision is needed to serve our oldest citizens.

Immediate Objectives (2003-2004):

- Implement the Senior Care Options (SCO) program for dual eligible elders and evaluate its success for possible expanded opportunities.

- Apply for a Medicaid waiver to allow a same-sex domestic partner to remain in the couple's home when one partner enters a nursing home.

- Eliminate tax benefits for trusts used to circumvent the Medicaid "spend down" requirement, and impose a tax on such instruments that provides funding for a state Medicaid match to support nursing home management initiatives such as the "Career Ladder" training program, use of e-medicine, or use of nurse-practitioners to provide case management to reduce emergency department use.

- Institute regulations to encourage and promote safe, cost-effective recycling of medications in long-term care facilities and provide adequate compensation for administering the process.

- Develop initiatives to ensure that nursing homes and long-term care facilities are competently serving Lesbian, Gay, Bisexual, and Transgender elders, and include questions of relevance to these seniors in needs assessments of elders.

Short Term Objectives (2005-2010):

- Develop a system to require those who have sufficient resources to be considered a "private pay" resident for admission to pay up front for long term care equivalent to one year of nursing home care.

- Require long-term care facilities to present plan of closing in a hearing before the Department of Public Health ninety days prior to closing.

- Establish family support alternatives beyond nursing home care.

- Establish minimum standards for medication management in community-based home care and assisted living facilities, including the role of the pharmacist, and education and training of personnel.

- Implement programs to train family members and others to serve as caregivers to elders who want to remain in their homes or in the least restrictive setting for their needs. Establish family support alternatives beyond nursing home care.

- Ensure that nursing home residents can leave the facility for over nights and vacations with family members without losing their placement.

- Implement a shift from the current institutionally based system for long-term care to one that is extended to community-based care within the community.

- Revise state laws to incorporate changes in the Controlled Substances act to eliminate unnecessary controlled substance waste in long-term care facilities and enhance the ability of seniors to receive appropriate pain management.

- All Medicaid residents in the long term care facilities will be evaluated for appropriateness of placement and all those identified as inappropriate will be moved back to the community with needed support.

Long Term Objectives (2011-2015):

- Establish a program to ensure that all Massachusetts residents by age sixty will have long term care insurance to supplement any benefits available under Medicare or Medicaid.

- Expand home health care, home-based long-term care options, and other aids to promote the ability of individuals to be cared for at home.

GOAL 10: FOCUS ON COMPASSIONATE END OF LIFE.

To achieve a system of compassionate end of life care for all Massachusetts residents whenever needed.

Our culture fails to accept the inevitability of death and uses resources inappropriately in extending life, where there is little value in that extension to the person who is near the end of life. There is great value in enabling a dying person to possess the most secure, most nurturing environment in which one can face the end of one's life. Health care providers need permission to behave in a manner, which allows the patient the dignity and quality of life that they deserve. The enormous challenge is to educate our citizens in the value of a peaceful death. Is it, for example, appropriate to expend huge resources in maintaining a life for a few days, when that individual is denied the choice of a peaceful dignified death, and when those limited dollars could be more effectively spent intercepting and managing chronic diseases that are currently placing great stress on the Commonwealth's ability to finance the system? It is a debate that our society must begin to address.

Immediate Objectives (2003-2004):

- Implement a pediatric palliative care program to respond to the needs of terminally ill children.

Short Term Objectives (2005-2010):

- Maintain and encourage growth in hospice programs to effectively serve those with terminal health conditions.
- Encourage efforts to establish a multi-faceted palliative care initiative with involvement from both institutional and community-based health service entities.

Long Term Objectives (2011-2015):

- Encourage education of both providers and the public of the range of care options available to them.
- Encourage use of and respect for advance directives such as "living will," "Do Not Resuscitate," etc.
- Guarantee that every citizen of the Commonwealth will receive end of life care when needed.

Policy Implementation Plan

Massachusetts Health Policy Coordinating Council

There shall be an entity known as the Massachusetts Health Policy Coordinating Council, established by statute, to guide the implementation of the policy and to provide revisions where appropriate. The Council shall invite the stakeholders involved in each objective to assist with the implementation and evaluation of progress for each objective. In addition, the Council shall identify an appropriate state or non-profit organization to serve as lead agency for each objective, gain concurrence in accepting this responsibility, and designate those responsible as lead agencies or organizations to implement the short term and long term objectives. In addition, the Council shall review and report to the public and stakeholders regarding the progress in achieving the goals and objectives of the Policy.

The Council is expected to develop performance measurement benchmarks for goals and objectives in consultation with lead agencies and organizations, and to measure progress toward achieving those benchmarks on an annual basis. Reports of the Council

should be made available electronically and annual public hearings will be planned to obtain input from stakeholders and the general public regarding any revisions of goals or objectives. The Council may establish and Advisory Council to allow the broadest possible involvement of stakeholders in the review of progress.

The initial work of the Council will focus on determining whether the short term objectives are realistic within the five year timetable, and whether any should be moved into long term status. The Council would work to prioritize objectives that are achievable within existing resources and identify potential additional resources based upon an assessment of the impact on health status and the economy of the issues identified in the policy goals and objectives. Whenever possible, cost estimates and cost-benefit ratios should be obtained relative to major remedies or strategies. At the same time, lead agencies and organizations should be identified and commitments obtained from them to be responsible for implementation of their designated objective(s).

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Appendix A

The Commonwealth of Massachusetts

IN THE YEAR TWO THOUSAND AND THREE

AN ACT FOR A CARING COMMONWEALTH; DEFINING THE HEALTH CARE POLICY OF THE COMMONWEALTH; HEALTH CARE POLICY COUNCIL ESTABLISHED.

SECTION 1. Section 16 of chapter 6A of the General Laws, as most recently appearing in the 2000 Official Edition, is hereby amended by inserting after the first paragraph, the following: "and the Massachusetts Health Policy Coordinating Council."

SECTION 2. Chapter 6A of the General Laws, as most recently appearing in the 2000 Official Edition, is hereby amended by inserting after Section 16C, the following new section:

Section 16D. Massachusetts Health Policy Coordinating Council.

Section 16D. There shall be a Massachusetts Health Policy Coordinating Council within the executive office of health and human services to guide the implementation of the health care policy of the Commonwealth established pursuant to the health care policy framework set forth in section 3 of this act, and to recommend revisions of said policy to the General Court where appropriate. The Council shall review the goals set forth in said section 3, shall develop the objectives necessary to attaining said goals and an estimate of their cost as well as the effects on the improvement of health status and the economy, assign short-term and long-term status to said objectives, and shall identify and, subject to their concurrence, designate those lead agencies and public or private organizations to be responsible for implementation of specific objective(s). The Council shall invite the stakeholders involved in each objective to assist with the implementation and evaluation of progress for each objective. In addition, the Council shall identify an appropriate state or non-profit organization to serve as lead agency for each objective, gain concurrence in accepting this responsibility, and designate those responsible as lead agencies or organizations to implement the short term and long term objectives. The Council shall, not less than annually, review and report to the public and stakeholders regarding the state of health care in the Commonwealth including the progress in achieving the goals and objectives of the policy.

In addition to such duties as may be assigned by law or by direction of the secretary of health and human services, the Council shall develop performance measurement benchmarks for goals and objectives in consultation with lead agencies and organizations, and to measure progress toward achieving those benchmarks on an annual basis. Reports of the Council shall be made available electronically and annual public hearings shall be held to obtain input from stakeholders and the general public regarding any revisions of goals or objectives. The Council may establish an advisory commission to allow the broadest possible involvement of stakeholders in the review of progress.

The Council membership shall consist of thirty-five (33) members who shall be the Governor, Lt. Governor, Senate President, and House Speaker, the Secretary of Health and Human Services, Commissioner of Public Health, Commissioner of Mental Health, the Commissioner of Insurance; the Executive Director of the Group Insurance Commission, the Chancellor/Dean of the University of Massachusetts Medical School, the Senate and House Chairs of the Joint Committee on Health Care, who shall serve while they hold office; and twenty-one members appointed by the governor for terms of two years, to include a representative of the public health field, a representative of the mental health field, a representative of pediatric health care, a representative of community or neighborhood health centers, two representatives of long-term care, one representing skilled nursing facilities and one representing home care; a representative of hospice care, a representative of teaching hospitals, a representative of community hospitals, a representative of the medical profession, a representative of the nursing profession, a representative of the pharmacy profession , a representative of a health insurance indemnity company, a representative of managed care organizations; a representative of a health care advocacy organization, a representative of the biomedical or pharmaceutical fields, a representative of a local or regional public health organization, a representative of employer-sponsored health benefits; a representative of small business and two representatives of health care consumers. The secretary of the executive office of health and human services shall serve as the chair.

SECTION 3. Chapter 6A of the General Laws, as most recently appearing in the 2000 Official Edition, is hereby amended by inserting after section 16D, the following new section,

Section 16E. Massachusetts Health Care Policy Framework.

Section 16E. The strategic goal of the health care system in the Commonwealth shall be to reduce the burden of physical and mental illness, injury, and disability, and to improve the overall health status and function of all Massachusetts residents including an emphasis on closing the gaps in health status by addressing the unique needs of vulnerable populations.

To that end, the following operational goals shall be the focus of the health care system: 1) to improve the patient experience with health care promoting safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity; 2) to strengthen

prevention and care management as the primary objectives of all primary care; 3) to guarantee that every resident has health insurance and access to health care for both physical and mental health needs and that this insurance adequately compensates providers for care; 4) to strengthen the public health system in the Commonwealth and its communities, to implement the objectives of Healthy Communities 2010, and to effectively respond to the threat of bio-terrorism or natural disasters through an "all hazards approach;" 5) to strengthen the emergency medical system and bioterrorism preparedness in the Commonwealth, and to increase the ability of individuals and communities to respond to medical emergencies and mental health episodes; 6) to establish a funding mechanism to support the physical and mental health needs of the Commonwealth during cyclical economic downturns; 7) to develop a system to ensure an adequate supply of highly competent, empathic health care and scientific research professionals to meet the workforce needs of the Commonwealth supported by the latest, most effective biomedical and pharmaceutical research as well as medical technology and health management and information systems; 8) to encourage the economic success of the health care system in its role as a major component of the Commonwealth's economic prosperity so that Massachusetts is a national leader in medical and bio-medical technology; 9) to achieve a system of compassionate end of life care for all Massachusetts residents whenever needed; and 10) to develop a system to provide care with dignity in the least restrictive environment appropriate to the needs of each individual and their family.

SECTION 4. Effective Date.

This act shall take effect upon passage.

Appendix B

Pittsburgh Regional Healthcare Initiative

At the "Point" of Patient Care

In 1998, Pittsburgh leaders discovered a missing piece in an ambitious regional economic strategy: a plan for the healthcare industry. This was significant, considering that in Southwestern Pennsylvania, health care is the largest sector of the economy, employing one in eight workers and conducting more than $7.2 billion in business.

Yet the industry was under growing pressure, with bankruptcies, operating losses, consolidations, and difficulty retaining qualified workers. Purchasers bemoaned the high cost of care; our quality indicators did not set national records.

To build opportunities out of these challenges, the Pittsburgh Regional Healthcare Initiative (PRHI), under the leadership of former U. S. Treasury Secretary and Alcoa Chairman Paul O'Neill, and Jewish Healthcare Foundation President Karen Wolk Feinstein, was formed. The initiative set out to make the region a leader in performance excellence.

Redesigning health care would require cooperation among previously competing interests. Through extensive outreach, PRHI brought these stakeholders together to pursue a common goal: perfecting the healthcare system. All involved have come to realize that the challenges facing health care are symptoms of the same root problem: not faulty people, but faulty, error-prone systems that do not focus on patients at the point of care.

Since 1998, PRHI has focused on these goals:

- Patient Safety. Zero medication errors and hospital-acquired infections. Pittsburgh is the only community in the country where competing hospitals have agreed to share sensitive data on medication errors and infections, and work together to bring the numbers to zero. The Centers for Disease Control and Prevention in Atlanta has offered its partnership in the belief that this model may lead to breakthroughs with national implications.

- Clinical Initiatives. Achieve the world's best patient outcomes in five clinical areas. Hundreds of area physicians have produced sophisticated databases to compare patient outcomes and have begun collaborating to improve care in: cardiac surgery, hip and knee replacement surgery, maternal and child outcomes (obstetrics), depression and diabetes.

- Perfecting Patient Care System. Design the organization in a way that allows everyone to learn from errors and problems, improving healthcare delivery processes quickly, frequently, and at low cost. Adapted for use in health care by PRHI from the principles of the Toyota Production System.

Perfecting Patient Care System

Is it possible to improve an incredibly complex system-health care-using a design from other industries? One Pittsburgh company, Alcoa, showed how it could be done. Now, PRHI is busy adapting that successful industrial model to health care.

Alcoa prepared its organization for a total systems approach by pioneering work in the area of worker safety. The result was America's safest workplace. The lost-day injury rate for Alcoa workers is 1/18 that of healthcare workers. As Alcoa became more skilled in problem solving, the organization was ready to start applying principles of the Toyota Production System (TPS)* to its manufacturing processes. Since 1998, Alcoa's costs have plummeted by $1.1 billion.

PRHI has developed the Perfecting Patient Care System, based on the tenets of TPS. In several hospital units across the region, Perfecting Patient Care (PPC) Learning Lines, unique problem solving laboratories, design solutions to problems interfering with meeting patient needs. Working with a Team Leader, those on the Learning Lines apply a specific discipline to solving problems immediately, in the course of work.

The PPC approach sets PRHI apart from many other healthcare reinvention efforts. With PPC, everyone in the care continuum works toward the ideal: delivering patient care on demand, defect free, one-by-one, immediately, without waste, in an environment that is physically, emotionally, and professionally safe.

PRHI's initial forays introducing the PPC System to medicine have demonstrated some promising gains. Sharing the findings with all healthcare stakeholders will be an important component of the regional learning network.

What is an A-3?

It's no mystery. The term A-3 is the name given to 11" by 17" sheets of paper--the size used for this planning device. A-3s are tools of the Toyota Production System (TPS), used to map out problems as they exist, define what the ideal situation would look like, and hypothesize how to get from here to there.

Why do we use them?

A-3s are a disciplined way of examining problems and creating solutions. In TPS, every problem is mapped this way, usually by hand, and used as a springboard for specific actions and measurements of progress. PRHI has adopted the A-3 across all disciplines represented.

The Coalition

PRHI's membership is not made up exclusively of healthcare providers. Rather, membership extends to all institutions in the region that have a stake in health care and are willing to make a commitment to improve it.

In addition to hundreds of clinicians, PRHI's members include 35 hospitals, four major insurers, over 30 major and small-business healthcare purchasers, dozens of corporate and civic leaders- and even Pennsylvania's attorney general. This coalition gives PRHI an unparalleled learning and improvement network.

This divergent group united in endorsing one guiding principle: health delivery will never achieve performance excellence until every care team is focused on perfect patient care. We will never achieve perfection until we regard every patient intervention as an opportunity to learn, share those learnings widely, and apply our discoveries.

In addition to a strong, committed regional partnership, PRHI has attracted national partners. The Centers for Disease Control (CDC) has extended a special program to all PRHI member hospitals. PRHI also received a $1 million Robert Wood Johnson Foundation grant, and a $4.8 million award from the Agency for Healthcare Research and Quality (AHRQ).

Appendix C

Summary of Budget Cuts to Health Care

The budgets of the state's Executive Office of Health and Human Services (EOHHS) and the Executive Office of Elders Affairs (EOEA) have been cut five times already, in the original fiscal year 2002 and fiscal year 2003 state budgets and in three rounds of "emergency 9c" cuts imposed by Governor Swift.

These programs and services are gone - already cut away completely in the FY 2003 budget:

- Line item 4000-0140 - The Betsy Lehman Center for Patient Safety and Medical Error Reduction. Funding of $200,000 in the FY 2003 budget was completely eliminated in a 9C cut by the Romney Administration delaying the center's effort to improve patient safety in the health system.

- Line item 1599-6900 - The Direct Care Worker Salary Reserve. Most community-based social services are not delivered by state employees. Rather, EOHHS and EOEA "contract out" these services to private, mostly non-profit, provider agencies. The state has so under-funded these contracts for years that the greatest problem disrupting the quality of care for our most vulnerable residents across the social services spectrum is extremely high staff turnover rates and chronic worker shortages. The average salary for a full time "Level 1" direct care worker is $18,442. This Salary Reserve account, funded with up to $28 million a year in the 90's, provided modest pay raises to these workers but it disappeared completely when successfully vetoed by Governor Swift in FY 2003.

- Line-item 4000-0870 - MassHealth Basic will be eliminated as of April 1, 2003. This Medicaid program currently provides about 46,000 individuals with limited health care coverage. These are very low-income people who are chronically unemployed or under-employed and are, in most cases, homeless. The average income of current MassHealth Basic recipients is $3,500 a year. Also, Adult Dental Care as a Masshealth benefit was completely eliminated in FY02 and coverage for eyeglasses, dentures, prosthetics, and other services was eliminated on January 1, 2003.

- Cuts to Mass Health Benefits: (530,000 recipients affected)

    - Dentures — State share $6,576,052
    - Prosthetics/Orthotics — State share $2,771,064
    - Chiropractic Therapy — State share $381,447

- Eye Glasses State share $575,020

- The Department of Public Health has been especially hard hit with over $100 million in cuts since FY 2001. DPH line items that have disappeared include: 4513-1021 – "Early Intervention" Respite Services (for families with at-risk infants to 3 year olds), 4513-1113 – Colorectal Cancer Awareness, 4513-1023 – Universal Newborn Hearing Screenings and 4518-0100 - Health Statistics Collection. The Department of Public Health: The hardest hit EOHHS agency, with an FY 2003 budget reduction of $86.5 million. Aids Prevention & Treatment - cut 5% ($2.1 million) in FY 2003 after a 19% reduction in FY 2002. Substance Abuse Services cut 11.9% ($5 million) in FY 2003. Tobacco Control Programs - cut 82.5% ($47 million). Prostrate Cancer Education - cut 71.5% ($2.4 million). Healthy Start - cut 22% (1,100 uninsured pregnant women will not receive prenatal care). Breast Cancer Awareness - cut 62.8% ($5.1 million). Community Health Centers Care Program - cut 20% (1,700 low-income uninsured persons will loss care) - and the list goes on!

- The Teen Pregnancy Prevention Challenge Fund has been cut by $1M, which will result in an elimination of most programs for the rest of this fiscal year. The Challenge Fund provides direct services to the highest-risk youth in Massachusetts, especially low-income teens and teens with the lowest MCAS scores. The Challenge Fund is a national model and the only community-based teen pregnancy prevention program in Massachusetts. Teen birthrates in communities with Challenge Fund programs have dropped by over 20% compared to average declines of only 5%.

- Smoking Prevention and Cessation. The DPH nationally acclaimed tobacco program has endured several cuts. Some school-based health centers are funded through a Department of Public Health line item aimed at Smoking Prevention and Cessation. cut from fiscal year 2002. This line item has been cut by almost $8M.

- $4 million cut to the Healthy Families Home Visiting Program, suspending the program as of the end of February. This is the 4th cut to this program. Over 3200 families will be terminated, and an additional 1200 eligible families will not be served. In 1998, Success By 6 in conjunction with the Children's Trust Fund and Healthy Families Massachusetts successfully advocated for a voluntary, universally accessible home visiting program for first-time parents under age 21 and their babies. In fiscal year 2002, $21M was appropriated for this program, a 400% increase in five years. Just over one year later, the program will essentially be eliminated for the rest of fiscal year '03. Cutting $4M from this program results in an overall 47%

- School Health Program - Gov. Mitt Romney using 9C powers eliminated the state's highly successful Enhanced School Health Program, which helps 106 communities provide nurses in schools, a shortsighted cut of an essential

health care service that will put children's health at risk. School nurses save tax dollars because they provide cost-effective early intervention for preventable but costly medical problems. Many families consider the school nurse as the first point of contact when their children have health problems.

Though the Romney Administration stated "preventative programs like these have been de-emphasized" the reality is that eliminating preventive programs results in increased costs for taxpayers. For families without health insurance, the school nurse may be the sole source of care with the exception of the emergency room, which ends up costing the state much more in the long run.

In addition, these nurses provide a crucial link between families and local health care providers.

Half of the $15.5 million in Enhanced School Health Service grants budgeted this year have already been distributed but Romney cut the remaining 40% of the funds that were scheduled to be distributed for the rest of this year. As a result of the reduction, most of the grant recipient schools are losing nursing positions.

The number of children in the public schools with some form of health condition has increased tremendously in the past decade, due largely to better diagnosis and treatment of chronic conditions. Many of these children have moderate to severe special health needs and are in the public schools today due to the availability of a school nurse.

Some students have chronic health conditions that require regular attention and the administration and monitoring of medications. These conditions include asthma, severe allergies, attention deficit disorder, psychiatric disorders, epilepsy and diabetes.

More than 2,000 registered nurses work in public and private schools around the state. The following is a partial list of services provided by school nurses:

- First aid for injuries and illness assessment.
- Intervention for chronic health problems.
- Physician referrals.
- State-mandated screenings for immunizations, vision and hearing.
- Maintenance of students' health records.
- Administration of daily medication, as prescribed by private physician.
- Medical liaison assistance for children with chronic or temporary disability.
- Individual health education and health counseling for students, parents and staff.
- Identification of environmentally sensitive students and staff.

- Referral of students and staff to appropriate community health agencies.

Because of past legislative support School Health programs were able to secure level funding for a total of $25,273,000 in FY 2003. The broad goal of these programs is to create and expand the Enhanced School Health Model throughout the Commonwealth through development of high quality school health programs. The Enhanced School Health Services Grant money provides for 109 districts (over 1000 public schools), 321 non-public and charter schools, and 77 recipient districts.

The school health programs have provided school districts with significant decrease in absenteeism for their students. School Health Care includes: communicable disease management and identification and referral of health issues such as vision, hearing, scoliosis and crisis. School Nurses manage chronic illness including asthma, diabetes, seizures, HIV and Cystic Fibrosis. Children can now receive the necessary care at school.

School Nurses have played a major role in providing access to the Mass Health Insurance Program. Mass Health submits administrative claims to the federal Government for the health services delivered by school nurses. These funds that are generated are known as FFP. For the $16 million dollar funding that Enhanced School Health Services received last year, school nurses generated $7 million in FFP (Federal Money).

Summary of accounts and services already cut at EOHHS

- Massachusetts Commission for the Blind: This small agency was cut by $195,102 in FY 2002, cut by another $566,832 in FY 2003 – over eight hundred persons who are blind have had services denied, eliminated, or reduced.

- Massachusetts Rehabilitation Commission: The following services for persons with disabilities have already been cut by the governor's FY 2003 vetoes - Vocational Rehabilitation - cut $507,016, Employment Assistance - $367,027, Independent Living Centers - $365,973. Intake for Voc Rehab has been closed after the waiting list reached 8,000 names.

- Massachusetts Commission for the Deaf and Hard of Hearing: Their FY 2001 budget of $5,656,825 was cut by $272,047 in FY 2002 and cut again by $207,391 in FY 2003. Agency staff reduced by over 16%, 2,900 requests for interpreters have gone unfilled, community services for 1,300 clients cut 8%.

- Department of Mental Health: Their FY 2003 budget is $13.8 million below their maintenance needs. Medfield State Hospital is closing. 328 clients will lose rental subsidies. Emergency Services cut 37%, denying 1,340 inpatient

bed "days" for 290 adults experiencing acute psychiatric emergencies. 45 DMH employees expected to be laid off from outpatient and day treatment programs in Boston, Lowell, Quincy, Fall River, Pocasett, and Brockton. - and DMH already has waiting lists with over 16,000 names for a variety of basic services.

- Department of Mental Retardation: Cut by $4.8 million just in FY 2003 vetoes by Governor Swift, over $13 million below their FY 2003 maintenance needs. 25% reduction in administrative staff expected from lay-offs and early retirements. 600 to 700 clients will lose transportation services they need to get to day programs. 254 clients may lose day services completely
- Department of Social Services: Domestic Violence Specialists cut 30%. Domestic Violence Emergency Shelters cut $87,509 at least 250 women and children will be refused emergency shelter.

Executive Office of Elder Affairs

- Protective Services - Cut 6% in FY 2002 ($642,000), eliminating 13% of its workforce (17 positions), elders reported to be abused or neglected now may be put on waiting lists.

- Elder Home Care Purchased Services - already cut $1.1 million in FY 2003, resulting in the programs caseloads being reduced by 106 frail elders each month.

- Prescription Advantage - Capped enrollment of new members in March 2003, and increased premiums and co-pays for current members effective April 1, 2003. Program slated to be completely eliminated by July 1, 2002 eliminating drug benefits for about 80,000 seniors and handicapped to save about $100 million.

- Mass MedLine - 800 phone line – an innovative public-private partnership between Elder Affairs and the Massachusetts College of Pharmacy that helps seniors get access to Pharmaceutical Manufacturer's free drug benefits and provide drug counseling will be terminated July 1, 2003 in order to save $250,000 a year.

Additional Health Cuts Planned for July 1, 2003

- Enrollments closed in CommonHealth Program for children and adults with disabilities and in the Family Assistance Program for children and parents over 133%fpl ($24,000 per family) and for all those with HIV regardless of income level. Could result in denial of coverage for 3,000 people.

- 6400 legal immigrants lose all but emergency MassHealth coverage.

- 13,000 new applicants for MassHealth will no longer qualify because of new asset and income rules.

- Children's Medical Security Program cut by reducing benefits and requiring higher premium payments.

- Uncompensated Care Pool – Providing "free care" to qualified individuals without health insurance coverage. Hospitals currently absorb any deficit in the pool. The Uncompensated Care Pool (the Pool) provides access to health care for low income uninsured and underinsured residents of Massachusetts. Established in 1985 and administered by the Division of Health Care Finance and Policy, the $345 million Pool is funded through a $215 million assessment on hospitals' private sector charges, $100 million from a surcharge on payments from private sector payers to hospitals and ambulatory surgical centers, and a $30 million contribution from the Commonwealth of Massachusetts.

  The Pool pays for medically necessary inpatient and outpatient services provided by hospitals and community health centers. The Pool is not insurance, and it does not pay for the cost of services provided by independent groups such as private physicians and specialty care groups. It can, however, provide some assistance to patients who are either uninsured or underinsured and meet the Pool's income and residency criteria.

  In Pool fiscal year 2002, the Massachusetts Uncompensated Care Pool paid for an estimated 30,000 inpatient admissions and 2 million outpatient visits. The most common users of the Pool are young adults ages 19-44 with incomes under the Federal Poverty Guidelines. More men than women use the Uncompensated Care Pool to pay for inpatient services, while more women use the Pool to pay for outpatient services.

  Over 80% of inpatient services paid for by the Pool are provided on an emergency or urgent basis. Over 35% of outpatient services paid for by the Pool were provided in an emergency department. Discharges for circulatory and digestive system diagnoses represent the greatest share of inpatient charges for free care patients. Mental health and alcohol and drug related disorders represent a much greater share of inpatient free care charges than they do for other payers, including MassHealth.

  The pool is expected to experience a shortfall in FY 2003 of ??? and this is expected to grow by about $160 million as former MassHealth Basic recipients turn to the Pool for their health care.

- Nursing Homes – User Fee. The nursing home user fee program, enacted in the FY '02 state budget, was designed to stabilize the state's struggling nursing homes without burdening the state budget, since the additional funds

would come from the Federal government. The fee was designed to provide a much needed increase in Medicaid rates.

Although the nursing home user fee program was not the ideal solution to address the nursing home crisis, it appeared to the Swift Administration and the Legislature to be the most viable solution considering the state's dwindling resources. The state Blue Ribbon Health Care Task Force report last year documented that nursing homes were in critical financial condition and that the state as the payor for 70% of nursing home residents needed to take an active role in stabilizing the problem. In response to these findings and growing concerns regarding the quality of resident care, nursing homes residents, their families, workers and providers asked us to respond to the growing crisis. The legislature acted by passing the nursing home user fee program into law as part of the FY 2003 budget.

The nursing home user fee program contains many important sections including the $50 million direct care labor add on, which will allow nursing homes to hire and retain critically needed staff in order to preserve quality resident care. We also included $12 million for capital rate enhancement to ensure that nursing homes have the resources needed to invest and maintain a nursing home's physical plant. We intended that all of this money should be spent as outlined in section 180 of the FY 2003 budget.

Governor Romney's budget proposal would divert funding from the nursing home user fee program will result in nursing home layoffs, cuts in services and closures. This would be completely contrary to the intent of the legislation, which was to stabilize the Commonwealth's nursing homes and preserve quality resident care. Nursing homes simply cannot sustain both the 9C nursing home rate cut effective March 1st and the Romney Administration's intention to alter the user fee program.